

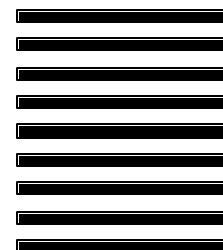
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DEPARTMENT OF SOCIAL & HEALTH SVCS  
DIVISION OF CHILD SUPPORT  
PO BOX 9008  
OLYMPIA WA 98507-9884





STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
DIVISION OF CHILD SUPPORT (DCS)

**APPLICATION FOR FULL COLLECTION SERVICES**

I understand and agree to the terms stated in the DSHS 16-072, **Nonassistance Support Enforcement Information**. I request the Division of Child Support to provide full collection services on my child support order.

***Please print or type all responses except your signature.***

\_\_\_\_\_  
MY FULL NAME

\_\_\_\_\_  
OTHER PARENT'S FULL NAME

\_\_\_\_\_  
MY TELEPHONE NUMBER (INCLUDE AREA CODE)

\_\_\_\_\_  
OTHER PARENT'S DATE OF BIRTH

\_\_\_\_\_  
MY PO BOX OR STREET NUMBER

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
MY CITY, STATE, AND ZIP CODE

\_\_\_\_\_  
DATE

I would like information on electronic direct deposit of my child support payments: ☐ Yes

☐ No

Case #: